

REFERRAL SCRIPT: UW WELL-FIT EXERCISE PROGRAM

Name of Client:	Phone:
Email:	Date of Birth:

Referral for UW WELL-FIT exercise program.

- In treatment
 Post treatment (within 2 years)

Note: All programs are fully or partially funded. Program options include in-person or remote. Fees will be outlined during initial contact and will depend on available funding.

Cancer Medical Information:

Type of cancer	Date of diagnosis
Type of surgery	Date of surgery

Treatment protocol:	Chemotherapy	Radiation Therapy	Hormonal Therapy
Drug			
Frequency			
Start date			
Length of treatment			
Finish date			

Resting Heart Rate		Resting Blood Pressure	
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Additional Medical Concerns:

<input type="checkbox"/> cardiovascular	
<input type="checkbox"/> metabolic	
<input type="checkbox"/> musculoskeletal	
<input type="checkbox"/> other	

This patient is cleared to participate in one of the following:

- progressive physical activity with avoidance of: _____
 unrestricted physical activity (start slowly and build up gradually)

Referred By: (Please print)	Designation:
Signature	Date

Fax to UW WELL-FIT: 519-888-4033

CCCARE staff will call the patient to book an assessment (519-888-4567 Ext. 46841)